		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033498

Facility Name: Coventry Village

Address: 612 W. St. Mary's Road (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-9020 **Fax #** (815) 626-6434

IDPA ID Number: 36-3549632-001

Date of Initial License for Current Owners: 3/27/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark A. Hull **Telephone Number:** (574) 239-7883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Harris F. Webber
(Title) General Partner

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Scott E. Martin, Crowe Chizek & Co. LLP
(Firm Name & Address) 330 E. Jefferson Blvd. PO Box 7, South Bend, IN 46624
(Telephone) (574) 236-7837 Fax # (574) 239-7871

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,190	5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,506	15,348	2,513	40,367	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,387		1,387	12
13	DD 16 OR LESS					13
14	TOTALS	22,506	16,735	2,513	41,754	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.00%

D. How many bed-hold days during this year were paid by Public Aid?
277 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/27/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,513

Medicare Intermediary AdminaStar Federal - Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	185,593	23,630	7,631	216,854		216,854		216,854			1
2	Food Purchase		252,776		252,776		252,776	(3,240)	249,536			2
3	Housekeeping	99,896	22,774	1,012	123,682		123,682		123,682			3
4	Laundry	65,813	23,482		89,295		89,295	(12,502)	76,793			4
5	Heat and Other Utilities			133,188	133,188		133,188		133,188			5
6	Maintenance	58,122	6,652	34,083	98,857		98,857		98,857			6
7	Other (specify):*											7
8	**TOTAL General Services**	409,424	329,314	175,914	914,652		914,652	(15,742)	898,910			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,575,879	76,536	175,655	1,828,070		1,828,070		1,828,070			10
10a	Therapy	127,235	562	8,953	136,750		136,750		136,750			10a
11	Activities	80,697	4,847	2,430	87,974		87,974		87,974			11
12	Social Services	65,757		180	65,937		65,937		65,937			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,849,568	81,945	192,718	2,124,231		2,124,231		2,124,231			16
	C. General Administration											
17	Administrative	68,493		334,477	402,970		402,970	(37,002)	365,968			17
18	Directors Fees											18
19	Professional Services			48,581	48,581		48,581		48,581			19
20	Dues, Fees, Subscriptions & Promotions			21,070	21,070		21,070	(1,649)	19,421			20
21	Clerical & General Office Expenses	61,290	15,586	54,371	131,247		131,247		131,247			21
22	Employee Benefits & Payroll Taxes			478,562	478,562		478,562		478,562			22
23	Inservice Training & Education			130	130		130		130			23
24	Travel and Seminar			20,143	20,143		20,143	(1,852)	18,291			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,616	98,616		98,616	(3,419)	95,197			26
27	Other (specify):*											27
28	**TOTAL General Administration**	129,783	15,586	1,055,950	1,201,319		1,201,319	(43,922)	1,157,397			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,388,775	426,845	1,424,582	4,240,202		4,240,202	(59,664)	4,180,538			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Coventry Village #0033498 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			184,576	184,576		184,576		184,576			30
31	Amortization of Pre-Op. & Org.			3,539	3,539		3,539		3,539			31
32	Interest			362,538	362,538		362,538	(6,150)	356,388			32
33	Real Estate Taxes			58,000	58,000		58,000		58,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,331	14,331		14,331		14,331			35
36	Other (specify):*											36
37	**TOTAL Ownership**			622,984	622,984		622,984	(6,150)	616,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,928	3,744	61,672		61,672		61,672			39
40	Barber and Beauty Shops			22,139	22,139		22,139		22,139			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,146	67,146		67,146		67,146			42
43	Other (specify):*	96,160	3,524	321,090	420,774		420,774	(420,774)				43
44	**TOTAL Special Cost Centers**	96,160	61,452	414,119	571,731		571,731	(420,774)	150,957			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,484,935	488,297	2,461,685	5,434,917		5,434,917	(486,588)	4,948,329			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,240)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(12,502)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,150)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(15,000)	17		17
18	Fines and Penalties				18
19	Entertainment	(1,852)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance	(3,419)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,649)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Cottage Expense	(420,774)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (464,586)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,002)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (22,002)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,588)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Coventry Village

ID# 0033498

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cottage Expense	$ (420,774)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(420,774)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Coventry Village # 0033498 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,240)	0	0	0	0	0	0	0	0	0	0	(3,240)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,502)	0	0	0	0	0	0	0	0	0	0	(12,502)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,742)	0	0	0	0	0	0	0	0	0	0	(15,742)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(37,002)	0	0	0	0	0	0	0	0	0	0	(37,002)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,649)	0	0	0	0	0	0	0	0	0	0	(1,649)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,852)	0	0	0	0	0	0	0	0	0	0	(1,852)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(3,419)	0	0	0	0	0	0	0	0	0	0	(3,419)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(43,922)	0	0	0	0	0	0	0	0	0	0	(43,922)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,664)	0	0	0	0	0	0	0	0	0	0	(59,664)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Coventry Village # 0033498 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,150)	0	0	0	0	0	0	0	0	0	0	(6,150)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,150)	0	0	0	0	0	0	0	0	0	0	(6,150)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(420,774)	0	0	0	0	0	0	0	0	0	0	(420,774)	43
44	**TOTAL Special Cost Centers**	(420,774)	0	0	0	0	0	0	0	0	0	0	(420,774)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(486,588)	0	0	0	0	0	0	0	0	0	0	(486,588)	45

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sterling Morris Retirement Associates Ltd Partnership	100%	Walnut Grove	Morris, IL	Harris Webber, LTD	Northbrook, IL	R.E. Development

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Management Fees	$ 319,477	Harris Webber, LTD		$ 297,475	$ (22,002)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 319,477			$ 297,475	$ * (22,002)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Harris F. Webber	General Partner	President	Genl Ptnr	71,062	661	31.78	Salary	$ 72,032	17, 7	1
2	Myra A. Webber	Treasurer	Clerical Support	0.00	4,828	331	31.78	Salary	4,894	17, 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 76,926		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Harris Webber, LTD
Street Address: 666 Dundee Road, Suite 930
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 272-9686
Fax Number: (847) 272-0524

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat & Other Utilities	Direct Cost	15,777,756	5	$ 5,808	$	5,014,143	$ 1,846	1
2	6	Maintenance	Direct Cost	15,777,756	5	6,410		5,014,143	2,037	2
3	11	Activities	Direct Cost	15,777,756	5	1,820		5,014,143	578	3
4	17	Administrative	Direct Cost	15,777,756	5	615,291	615,291	5,014,143	195,538	4
5	19	Professional Services	Direct Cost	15,777,756	5	21,494		5,014,143	6,831	5
6	20	Fees, Subscriptions & Promotions	Direct Cost	15,777,756	5	4,164		5,014,143	1,323	6
7	21	Clerical&General Office Exp	Direct Cost	15,777,756	5	33,008		5,014,143	10,490	7
8	22	Employee Benefits&Payroll	Direct Cost	15,777,756	5	99,605		5,014,143	31,654	8
9	24	Travel & Seminar	Direct Cost	15,777,756	5	4,065		5,014,143	1,292	9
10	26	Insurance - Prop, Liab, Mal	Direct Cost	15,777,756	5	12,057		5,014,143	3,832	10
11	30	Depreciaiton	Direct Cost	15,777,756	5	42,765		5,014,143	13,591	11
12	32	Interest	Direct Cost	15,777,756	5	3,309		5,014,143	1,052	12
13	34	Rent-Facility & Grounds	Direct Cost	15,777,756	5	73,367		5,014,143	23,316	13
14	35	Rent-Equipment & Vehicles	Direct Cost	15,777,756	5	12,887		5,014,143	4,095	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 936,050	$ 615,291		$ 297,475	25

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank		X	Mortgage	$14,130.50	11/07/87	$ 2,781,478	$ 1,573,508	12/01/08	8.7500	$ 160,609	1
2	National City Bank		X	Expansion Loan	$26,350.00	8/01/97	2,460,742	2,159,731	8/01/02	9.0000	201,929	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$40,480.50		$ 5,242,220	$ 3,733,239			$ 362,539	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,242,220	$ 3,733,239			$ 362,539	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 88,525	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 88,525	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 58,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 58,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	17,688	8
	1997	8,977	9
	1998	19,200	10
	1999	17,900	11
	2000	88,525	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Coventry Village COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0033498

CONTACT PERSON REGARDING THIS REPORT Mark Hull

TELEPHONE (574) 239-7883 FAX #: (574) 239-7871

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-151-002	PT W 1/2 NW, Sec 16 TWP 21	$ 88,758.82	$ 58,483.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,758.82	$ 58,483.34

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,746 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	95,000	1987	$ 59,079	1
2	Cottages		1987&1994	237,649	2
3	TOTALS	95,000		$ 296,728	3

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94			1987	$ 2,092,159	$ 52,304	40	$ 52,304	$	$ 669,386	4
5	36			1997	2,264,443	56,611	40	56,611		250,262	5
6				2000	150,000	4,262	35	4,262		6,393	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1989	179,998	12,000	15	12,000		152,710	9
10	Land Improvements			1990	4,960	331	15	331		3,804	10
11	Land Improvements			1991	13,522	1,231	15	1,231		12,925	11
12	Land Improvements			1992	895	60	15	60		568	12
13	Land Improvements			1993	3,878	259	15	259		2,642	13
14	Land Improvements			1994	12,806	854	15	854		5,883	14
15	Land Improvements			1995	1,165	78	15	78		507	15
16	Land Improvements			1997	564	38	15	38		171	16
17	Land Improvements			1998	2,011	134	15	134		469	17
18	Land Improvements			2001	1,000	33	15	33	1/2 year	33	18
19	Land Improvements			2001	2,525	84	15	84	1/2 year	84	19
20											20
21	Building Improvements			1992	5,706	306	15	306		2,887	21
22	Building Improvements			1993	3,541	181	15	181		1,537	22
23	Building Improvements			1994	12,322	647	15	647		4,852	23
24	Building Improvements			1995	33,652	2,548	15	2,548		15,900	24
25	Building Improvements-Heat Pump			1996	3,980	266	15	266		1,462	25
26	Building Improvements-Heat Pump			1997	5,580	347	15	347		1,597	26
27	Building Improvements-Floor Tile			1997	705	71	10	71		284	27
28	Building Improvements-Shower Room Improvement			1997	2,227	172	12.5	172		774	28
29	Building Improvements-Hallway Renovations			1998	21,813	1,454	15	1,454		5,090	29
30	Building Improvements-Painting			1998	10,886	726	15	726		2,541	30
31	Building Improvements-Heat Pump			1998	8,530	569	15	569		1,991	31
32	Building Improvements-Painting			1999	3,853	257	15	257		642	32
33	Building Improvements-Water Softener			1999	4,144	276		276		690	33
34	Building Improvements-Corrider Handrail Remode			1999	29,791	1,525		1,525		4,504	34
35	Building Improvements - Flooring in 10 Rooms			2001	5,340	381	7	381		381	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,881,996	$ 138,005		$ 138,005	$	$ 1,150,969	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,100,269	$ 36,095	$ 36,095	$		$ 890,425	71
72	Current Year Purchases	23,415	3,559	3,559			3,559	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,123,684	$ 39,654	$ 39,654	$		$ 893,984	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Van - 1994	1994	$ 48,424	$ 6,917	$ 6,917	$	7	$ 51,882	76
77										77
78										78
79										79
80	TOTALS			$ 48,424	$ 6,917	$ 6,917	$		$ 51,882	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,350,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,576	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,576	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,096,835	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottages	$ 6,413,375	$ 160,578	$ 961,355	86
87	Cottages-Improvements	131,306	28,497	42,517	87
88	Cottages-FFE	127,739	6,018	112,586	88
89	Cottages-Land Improvements	429,856	6,874	196,636	89
90					90
91	TOTALS	$ 7,102,276	$ 201,967	$ 1,313,094	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Apartments	$ 2,274	92
93	CIP - Cottages	90,380	93
94			94
95		$ 92,654	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 14,331 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		699	hrs	$ 16,495	84	$ 3,218	$ 562	783	$ 20,275	1
2	Licensed Speech and Language Development Therapist			hrs		25	1,752		25	1,752	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		3803	hrs	79,787	56	1,258		3,859	81,045	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation		1548	hrs	30,953	136	2,725		1,684	33,678	8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 127,235	301	$ 8,953	$ 562	6,351	$ 136,750	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 199,063	$	1
2	Cash-Patient Deposits	6,418		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (125,285))	801,468		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,081		6
7	Other Prepaid Expenses	35,180		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,063,210	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	296,728		13
14	Buildings, at Historical Cost	11,856,534		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,299,845		16
17	Accumulated Depreciation (book methods)	(3,369,984)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spc CIP	92,654		22
23	Other(specify): Loan Fees Net	46,189		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,221,966	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,285,176	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 502,396	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,141		28
29	Short-Term Notes Payable	157,466		29
30	Accrued Salaries Payable	220,440		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,434		32
33	Accrued Interest Payable	28,673		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	669,556		36
37		95,747		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,815,853	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,733,239		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Cottage Deferred Income	6,371,181		43
44	Entrance Fee Liability	593,704		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,698,124	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,513,977	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,228,801)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,285,176	$	48

***(See instructions.)**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,097,018)	1
2	Restatements (describe):		2
3	**Prior period audit adjustments**	5,722	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,091,296)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(75,241)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(62,338)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Offage**	74	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (137,505)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,228,801)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,656,132	1
2	Discounts and Allowances for all Levels	(239,455)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,416,677	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	339,638	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 339,638	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	27,559	13
14	Non-Patient Meals	3,240	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	54,928	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	139	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,589	21
22	Laundry	12,502	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 104,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,150	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,150	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cottages	492,256	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 492,256	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,359,678	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	914,652	31
32	Health Care	2,124,231	32
33	General Administration	1,201,319	33
	B. Capital Expense		
34	Ownership	622,984	34
	C. Ancillary Expense		
35	Special Cost Centers	504,585	35
36	Provider Participation Fee	67,146	36
	D. Other Expenses (specify):		
37	Rounding	2	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,434,919	40
41	**Income before Income Taxes (line 30 minus line 40)****	(75,241)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (75,241)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,784	1,968	$ 50,495	$ 25.66	1
2	Assistant Director of Nursing	1,567	1,983	35,844	18.08	2
3	Registered Nurses	10,118	10,942	227,449	20.79	3
4	Licensed Practical Nurses	21,258	22,629	386,430	17.08	4
5	Nurse Aides & Orderlies	75,224	79,026	806,904	10.21	5
6	Nurse Aide Trainees	6,589	7,120	55,480	7.79	6
7	Licensed Therapist	4,408	4,705	96,281	20.46	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,768	1,968	23,173	11.77	9
10	Activity Assistants	6,848	7,266	57,524	7.92	10
11	Social Service Workers	2,561	2,846	65,757	23.11	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,088	29,622	14.19	13
14	Head Cook	5,587	6,091	52,795	8.67	14
15	Cook Helpers/Assistants	15,640	16,555	103,176	6.23	15
16	Dishwashers					16
17	Maintenance Workers	5,431	5,945	58,123	9.78	17
18	Housekeepers	12,454	13,316	99,896	7.50	18
19	Laundry	8,296	8,731	65,813	7.54	19
20	Administrator	1,960	1,960	68,494	34.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,837	7,360	61,290	8.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	2,696	2,868	30,953	10.79	30
31	Medical Records	1,900	2,108	13,924	6.61	31
32	Other Health Care(specify)	8,462	9,094	95,512	10.50	32
33	Other(specify) Cottages					33
34	TOTAL (lines 1 - 33)	203,244	216,569	$ 2,484,935 *	$ 11.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	175	$ 7,631	Ln 1 Col 3	35
36	Medical Director		6,000	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	12	268	Ln 10a Col 3	40
41	Occupational Therapy Consultant	41	1,483	Ln 10a Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	26	1,803	Ln 10a Col 3	43
44	Activity Consultant	40	2,179	Ln 11 Col 3	44
45	Social Service Consultant	4	180	Ln 12 Col 3	45
46	Other(specify) Barber/Beauty		22,139	Ln 40 Col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	298	$ 41,683		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	217	$ 9,196	Ln 10 Col 3	50
51	Licensed Practical Nurses	1,870	58,242	Ln 10 Col 3	51
52	Nurse Aides	4,578	84,634	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	6,665	$ 152,072		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Connie Short	Administrator	N/A	$ 13,896
Frank Santore	Administrator	N/A	18,700
Tom Moen	Administrator	N/A	24,667
Mark Fedyk	Administrator	N/A	11,230
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,493

B. Administrative - Other

Description		Amount
Harris Webber Mgnt Services	Management Fee	$ 319,477
Harris F. Webber	Partnership Fee	7,500
Harris F. Webber	Guarantee Fee	7,500
TOTAL (agree to Schedule V, line 17, col. 3)		$ 334,477
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
Wildman, Harrold, Allen & Dixon	Legal	$ 12,523
Ward, Murray, Pace & Johnson	Legal	1,510
Crowe, Chizek & Company	Accounting	6,894
Misc. Computer Services	Miscellaneous	5,783
ADP	Payroll Services	9,613
Peak Personnel	Legal Fees	2,500
Misc. Professional Services		9,758
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,581

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	120,428
FICA Taxes	208,513
Employee Health Insurance	73,643
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	2,982
Employee Dental Insurance	14,275
401k Contributions	28,937
Other Employee Benefits	29,784
TOTAL (agree to Schedule V, line 22, col.8)	$ 478,562

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,496
Advertising: Employee Recruitment	8,676
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	3,402
Less: Public Relations Expense	(1,649)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,925

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Nursing Related in-state travel	14,453
Seminar Expense	771
Other Seminar	4,919
Entertainment Expense	(1,852)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,291

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repair Pipes	1994	$ 1,982	7	$ 283	$ 283	$ 283	$ 142	$	$	$	$	$
2	Heating & Cooling	1994	9,110	7	1,301	1,301	1,301	651					
3	Interior Maint	1994	1,092	7	156	156	156	78					
4	Heating & Cooling	1995	2,638	5	528	528	528	0					
5	Interior Maint	1995	1,376	5	275	275	275	0					
6	Make-up Air System	2/96	1,452	5	290	290	290	50					
7	No 1997 Additions												
8	No 1998 Additions												
9	No 1999 Additions												
10	No 2000 Additions												
11	No 2001 Additions												
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,650		$ 2,833	$ 2,833	$ 2,833	$ 921	$	$	$	$	$

Facility Name & ID Number Coventry Village **#** 0033498 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **No**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **18,043** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **67,146**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **None** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Crowe Chizek & Co. LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit not complete as of filing date**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.